

**CONFIDENTIALITY:** Any information exchanged on this form or during a session is strictly confidential. It will be used for the sole purpose of providing the best therapeutic services possible.

Name _____	Birthdate _____
Address _____	Phone (Home/Cell) _____
City, State, Zip _____	(Work) _____
Email _____	Occupation _____
Emergency Contact _____	Phone _____

Please take a moment to carefully read the following information and check where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please mark any areas of soreness or tension. Include any Description that you might deem necessary to assist treatment.

<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
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Do you suffer from any of the following health conditions?

<input type="radio"/> Stress	<input type="radio"/> Arthritis
<input type="radio"/> Contagious Disease	<input type="radio"/> Broken Bone(s)
<input type="radio"/> Varicose Veins	<input type="radio"/> Sprain or Strain (Ligament or muscle damage)
<input type="radio"/> High/Low Blood Pressure	<input type="radio"/> Skin Infection
<input type="radio"/> Cardiac/Circulatory Issue	<input type="radio"/> Numbness or Stabbing pain
<input type="radio"/> Diabetes	<input type="radio"/> Nerve Impairment
<input type="radio"/> Headaches	<input type="radio"/> Other: _____

Are you taking any medication?	YES	NO	
If so, please list: _____			
Have you recently been in a car accident?	YES	NO	
Have you recently been injured?	YES	NO	
If so, please describe: _____			
Do you bruise easily?	YES	NO	
Have you ever been diagnosed with Cancer?	YES	NO	
Are you Pregnant?	YES	NO	
If so, how far along are you?	1 <sup>st</sup> trimester	2 <sup>nd</sup> trimester	3 <sup>rd</sup> trimester
Have you ever had surgery?	_____		
If so, type and year?	_____		

Is this your first massage ever?	YES	NO	
If not, when was your last massage? _____			
What kind of pressure do you prefer?	Light	Medium	Firm
Are you wearing any of the following?	Contact Lenses	Dentures	Hairpiece

<b>What are your massage or bodywork goals?</b>
_____
_____
_____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone or email. I agree that I will pay for the missed appointment if I fail to cancel 24 hours in advance.

Client Signature _____	Date _____
Practitioner Signature _____	Date _____

**Consent to Treatment of Minor:**  
 By my signature below, I hereby authorize \_\_\_\_\_ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_